

# Strategies for Ensuring Quality Health Care in India: Experiences From the Field

Health care is one of India's most rapidly expanding sectors both in terms of revenue and employment. However, the question of whether the expanding industry size translates into better quality services and improving outcomes for patients still remains. In this regard, the government released the National Health Policy (NHP) 2017 to serve as a guiding document for the policymakers in the achievement of India's national goals and international commitments. NHP recognizes some key dimensions of high-quality healthcare – consistency, positive health outcomes, patient-centeredness, equity, and trustable service delivery.<sup>[1]</sup> Improving the quality of health care is also essential to meet the health-related targets of the Sustainable Development Goals (SDGs). SDGs lay importance on improving indicators relating to maternal, fetal, and neonatal care, which are areas where continuous quality enhancement is necessary to bring down the maternal mortality rates (MMR), infant mortality rates (IMR), neonatal mortality rate (NMR), and under-five mortality (U5MR).<sup>[2]</sup>

On the one hand, India has made ground-breaking progress in recent years in reducing the MMR by 77% (from 556/100,000 live births in 1990 to 130 in 2016) and child deaths by approximately 57% (from 14 million child deaths in 2000–2005 to 6 million in 2011–2015).<sup>[3]</sup> However, on the other hand, progress on both these key accounts missed the targets set under the 12<sup>th</sup> 5-year plan (2017) goals as well as the Millennium Development Goal. From the WHO Health Statistics 2016, one can find India lagging behind its neighbors such as Maldives, Sri Lanka, Nepal, and Bhutan in terms of indicators such as incidence of tuberculosis and premature deaths due to noncommunicable diseases.<sup>[4]</sup> India's average life expectancy (68.3 years) is some 10 years shorter than Maldives, drawing attention to some shortcomings in India's strategy for quality health. This is despite a decade of the ambitious National Health Mission implementation. Perhaps, patching the gaps in the ground-implementation of the pioneer programs of the government needs a determined revisit.

On maternal and child health, the NHP aspires to reduce U5MR to 23 by 2025 and MMR from current levels to 100 by 2020. It also aims to reduce IMR to 28 by 2019, NMR to 16 and stillbirth rate to “single digit” by 2025.<sup>[1]</sup> In this regard, the government's key intervention, i.e., universal health coverage under the Ayushman Bharat – Pradhan Mantri Jan Aarogya Yojna (AB-PMJAY), has caught onto the right priorities. However, ensuring replication of broader policy objectives onto the ground requires sustained effort and smaller reforms to ensure effectively translation of national goals into local realities. Effective health planning requires a consideration of the WHO

recommended key determinants, in which health care is simply an element. Besides, the health services, quality health needs interventions influencing other determinants of health such as culture, attitudes, income levels, nutritional status, hygiene and sanitation, lifestyle, social support, and among other things.

## ASSESSING GROUND REALITIES: EXPERIENCE FROM BANDA

Access to health care in India is scattered across geographical and income differentials. Therefore, each region's unique context is largely determinative of the success of any intervention. For informed policymaking and the implementation thereof, a deeper understanding of the ground challenges is essential to ensure efficient and adequate delivery of health services, especially in areas where quick and quality service delivery is imperative like maternal and child health. A field visit undertaken to the Banda district in Uttar Pradesh with the objective of assessing the utilization of the maternity services at both public and private facilities brought to light significant issues in infrastructure, human resource management, process integrity, and monitoring. In the case of referrals for high-risk pregnancy (HRPs), for instance, data analyzed from private hospitals suggested a delay in referral and complacency on the part of medical and antenatal staff in detecting such pregnancies that may pose grave danger to both mother and child if undetected. To be more specific, in October 2018, 41,887 pregnant women in their last menstrual cycle were registered on the central server for the district, with 13,419 tagged as risk cases and only 1907 as high risk. This immediately catches attention since in any usual context; about 10% of cases are HRPs. Thus, there is substantial under-detection of high-risk cases despite the presence of incentive-based programs for accredited social health activist (ASHA) workers in the state.<sup>[5]</sup>

Even in cases that are identified, there is usually a very late referral that may put the mother and child at risk. These issues remain even though routine antenatal care (ANC) is mandated and promoted under the Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA). The situation is exacerbated due to a lack of institutional capacities and monitoring systems. For instance, while the medical college hospital and district hospital in Banda have qualified Obstetric (OB)/Gynaecology specialists as well as anesthetists on their rolls, emergency medical OB care is not available at these facilities, forcing patients to be referred to other centers. Moreover, a disconnect between community health centers (CHCs) and district hospitals means that majority of the referrals either land up in private hospitals in Banda or have to go to the nearby city of Kanpur.

To alleviate the situation, some short-term action points were suggested in the governance model to address key challenges. Primarily, a review of the existing quality of ANC, with special emphasis on the identification of HRP, needs to be undertaken. Thereafter, localized plans, at the primary health center (PHC) level need to be developed for registration, follow-up appointments and timely referral of HRPs to appropriate facilities (public or private). To ensure synergy with the AB, focus on developing a model for referral arrangements with private health providers at PMJAY rates is a must. This localized system would also require institutionalization of a monitoring system. This model would also need support in the form of capacity building initiatives for ANMs and ASHA workers, including mentoring for detection of HRPs. Overhauling the implementation of the PMSMA for detection of HRPs and ensuring availability of iron and folic acid and oxytocin are other focus areas.

### PUTTING FIELD LEARNINGS INTO ACTION

It needs no reiteration that bridging the gap between the aspirations of NHP and AB-PMJAY and the ground reality requires a systematic approach, involving both private service providers and government institutions. The experience from Banda is unique but overall has some essential learnings for the Indian health-care system as a whole.

First, challenges of inadequate facilities, infrastructure, coverage, access, and quality continue to plague the health system. Over 95% of facilities function with less than five workers, and only 195 hospitals in the entire nation operate with quality certifications. Essential diagnostics such as mammograms have scant coverage of only 1%. Second, the complacency of the medical staff in discharging their duties is a universal reality in the nation. Empirical studies indicate that health-care professionals in rural areas with requisite formal medical training do not provide any significant higher-quality care when compared to informal providers. This is further complicated by the fact that there is a persistent shortage of human resources in health in India – 0.7 doctors available per 1000 population as compared to the WHO recommended 1:1000 ratio.

While one would expect private sector care to have higher quality, there is increasing evidence suggesting poor quality in the private sector. Problems with the public and private health setup are largely the same – gulf of difference between the reported and actual diagnostic and treatment facilities, the tendency of over-prescribing and subjecting patients to unnecessary interventions, lack of efficient monitoring mechanisms, and poor implementation of regulatory controls.

Moreover, the lack of universal coverage, access, and affordability across regions also hampers attainment of high-quality health outcomes. As per the 2016 Health Access and Quality Index, India performs only averagely in South Asia with a score of 41.2 (leading marginally from Pakistan, Nepal and Afghanistan) but lagging far behind Bhutan (47.3), Bangladesh (47.6), and Sri Lanka (70.6), even though India performs better than these nations on economic indicators.<sup>[6]</sup>

Hence, to address these challenges and meet the objectives set out in NHP, India requires significant investment and upgradation of quality standards. While the government is constantly increasing its financial input into health systems reform, focus needs to be on quality consciousness and assurance mechanisms, especially since there has been a growing demand from consumers for better quality healthcare. There needs to be marriage between quality assurance and quality improvement. While the former's focus is on ensuring requisite infrastructure, supplies, and trained workforce, the latter relies on the process of equipping the health-care workers and managers with skills to identify and solve problems at their level. Access to quality healthcare can also go a long way in reducing the overall cost of health care, by reducing complications, reoccurrence, and treatment periods. To ensure continuous progress toward both regulations and accreditations are key.

Regulations needed include a re-assessment of existing policies and programs to see what works and what needs rework. For example, the National Health Mission's inability to achieve targets relating to IMR and MMR despite high budgetary allocation is a key priority. Quality controls in the form of accreditations, like the ones established by National Accreditation Board for Hospitals and Health-care Providers (NABH), also help ensure a strong focus on patient rights and benefits, safety, control, and prevention of infections in hospitals, and proper protocols such as special care for vulnerable groups, critically ill patients, and better and controlled clinical outcome. The existing accreditation ecosystem and quality frameworks in India are quite robust and comprehensive, and hence, it is pertinent to promote their adoption. Interventions into quality promotion, such as Indian Public Health Standards 2008, National Quality Assurance Standards (NQAS) 2013, Mera-Aspataal (My Hospital) 2016, LaQshya (Labour room Quality Improvement Initiative) 2017, and National Patient Safety Implementation Framework (2018–2025), can also help jumpstart the journey in this direction.

Quality is also a function of equity. Put differently, regional and income disparities should not hinder access to quality health care. NITI Aayog's Health Index places Kerala on top and Uttar Pradesh at the bottom across indicators such as IMR, sex ratios at birth, immunization, proportion of people living with HIV/AIDS, and incidence of tuberculosis.<sup>[7]</sup> Uniform regulation, implementation, monitoring, and accreditation coupled with a study into and attempts to address the region-specific challenges can help reduce geography-based imbalances. The AB-PMJAY already attempts to tackle the economic inequity to accessing quality health care through universal health coverage but needs more effort in securing efficient translation on the ground. Banda's experience also highlights the need for elaborate and systematic stakeholder management, especially the need to onboard the private sector on the technical and informational aspects of the national program.

For central policy focus and assessment, international targets and standards might serve as a credible guide. The WHO Global Nutrition Targets for 2025 deserve mention here, and India

should aim to achieve them, especially those highlighted in the Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition. This plan lists out a set of six global nutrition targets to be achieved by 2025, including a 40% reduction in the number of children under-5 who are stunted; a 50% reduction of anemia in women of reproductive age; and reduction and maintenance of childhood wasting to <5%, among others – all imperative for a developing, young nation like India.<sup>[8]</sup>

Finally, receptiveness to and quick adoption of innovations can aid quick acceleration to the ambitious goal of quality health care. This, in turn, needs investment into and institutionalization of innovative approaches in the existing system.

## WAY FORWARD

Above suggested changes can act as a catalyst to achieving the medium-term goals set out by NITI Aayog in its 2022 Health Care Strategy which focuses on four crucial parameters, foremost of which is the revamp of the public and preventive health systems. This is planned to be achieved by co-location of AYUSH services in 50% of PHCs, 70% of CHCs, and 100% of district hospitals, instituting public health and management cadre in states, and creating a focal point for public health at the central level with state counterparts.<sup>[9]</sup> Thereafter, the strategy calls for promoting a new vision for comprehensive primary health services using health and wellness centers (HWCs). Therefore, the strategy calls for accelerating the establishment of a network of 150,000 HWCs through commensurate enabling mechanisms for rapid scale-up. The strategy then turns focus to developing able human resources to operate these revamped networks. It calls for achieving a doctor-population ratio of 1:1400 and nurse-population ratio of 1:500 through reforms in the governance of medical, nursing, dentistry, pharmacy councils, and transforming the curriculum. This would need to exist within a framework of a comprehensive human resources for health policy in states. Finally, the strategy focuses on boosting coverage of the publicly financed health-care system. The same can be achieved by covering 75% of India's population under AB-PMJAY with inbuilt quality improvement and assurance mechanism and strengthening public sector health facilities – something that India is currently making good progress toward.

While all these are apt pillars for a medium-term roadmap for the Indian health system, the strategy also assumes a bedrock of quality assurance and adherence. Ensuring high quality implies achieving improvement in health outcomes, consistency in those outcomes, valued and trusted systematic processes, and institution of structures that are able to effectively respond to changing population needs and dynamics. Measurement and monitoring initiatives are essential to fix accountability. In this regard, institutional-level input measures such as NABH and NQAS, and district level outcomes like National Family Health Surveys are pertinent to be noted.

While coverage and quality might seem like a trade-off, an effective amalgamation of the two is imperative to achieving

our end goal, which is to attain and build the trust of the consumers. Quality is an invisible thread tying all these elements together and needs constant focus. This can be achieved only by simultaneous and synergistic implementation of the tools elaborated above, continuous learnings from the field, and most importantly, a receptiveness by all stakeholders to change for a healthier country.

Disclaimer: The views expressed are personal.

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